

The Ryan White HIV/AIDS Program

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Summary

The Ryan White HIV/AIDS Program makes federal funds available to metropolitan areas and states to assist in health care costs and support services for individuals and families affected by the human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS). The Ryan White program currently serves more than half a million low-income people with HIV/AIDS in the United States; 29% of those served are uninsured, and an additional 56% are underinsured. The program is administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS). Its statutory authority is Title XXVI of the Public Health Service (PHS) Act, originally enacted in 1990.

The Ryan White program is composed of four major parts and several other components. Part A provides grants to urban areas and mid-sized cities. Part B provides grants to states and territories; it also provides funds for the AIDS Drug Assistance Program (ADAP). Part C provides early intervention grants to public and private nonprofit entities. Part D provides grants to public and private nonprofit entities for family-centered care for women, infants, children, and youth with HIV/AIDS. The other components, sometimes referred to as Part F, include the AIDS Dental Reimbursement (ADR) Program, the Community-Based Dental Partnership Program, the AIDS Education and Training Centers (AETCs), the Special Projects of National Significance (SPNS) Program, and the Minority AIDS Initiative (MAI).

The Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148, as amended) contains general provisions to increase access to health insurance and which, therefore, should increase coverage for people living with HIV/AIDS. ACA includes prohibitions on the cancellation of coverage by an insurer due to a preexisting condition, elimination of lifetime caps on insurance benefits and annual limits on coverage, and eligibility for tax subsidies to assist low- and middle-income individuals in the purchase of coverage from state health insurance exchanges. ACA phases out the Medicare Part D doughnut hole for HIV/AIDS individuals who are Medicare eligible, and, at state option, Medicaid eligibility will be broadened to include single adults. There could be a significant impact on Ryan White ADAP clients in those states that decide to cover the new Medicaid eligible group; 56% of ADAP clients served in June 2011 would be eligible for Medicaid in 2014 if their states choose to participate in the expansion, and the remainder would likely receive assistance in purchasing health coverage on the exchange.

In October 2009, the 111th Congress passed and President Obama signed the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87), which reauthorized the Ryan White program through September 30, 2013. The long-range impact of ACA on the Ryan White program—meaning the replacement of health and treatment services provided under Ryan White with access to such services through health coverage via ACA—remains to be determined. In states that decide not to participate in the Medicaid expansion, the need for the full range of Ryan White services would remain. However, even if all states decide to cover the new Medicaid eligible group, there will be gaps that the Ryan White program could continue to fill, such as coverage of those individuals with HIV/AIDS who are undocumented immigrants. In addition, Ryan White provides dental care and support services, such as transportation, that may not be provided under Medicaid or private health insurance.

For FY2013, the Obama Administration requested a total of \$2.447 billion for the Ryan White program, an increase of \$80 million compared with FY2012; most of the increase (\$66.7 million) would go to the ADAP program. Congress provided temporary funding, through March 27, 2013, for the Ryan White program in P.L. 112-175, the Continuing Appropriations Resolution, 2013. Funding is at the FY2012 rate plus a very slight increase (less than 1%). The Budget Control Act

of 2011 (P.L. 112-25) sequestration, scheduled to occur on January 2, 2013, could cut HRSA discretionary programs, such as Ryan White, by 8.2%.

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The Ryan White HIV/AIDS Program makes federal funds available to metropolitan areas and states to provide a number of health care services for HIV/AIDS patients including medical care, drug treatments, dental care, home health care, and outpatient mental health and substance abuse treatment. The program currently serves more than half a million low-income people with HIV/AIDS in the United States; 29% of those served are uninsured, and an additional 56% are underinsured.¹

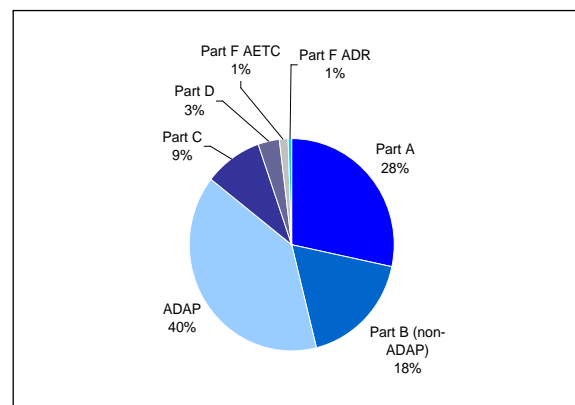
The Ryan White program was established in law in 1990 (P.L. 101-381) and reauthorized and amended in 1996 (P.L. 104-146), 2000 (P.L. 106-345), 2006 (P.L. 109-415), and 2009 (P.L. 111-87).² It was enacted as Title XXVI of the Public Health Service (PHS) Act and codified as Parts A, B, C, D, E, F, and G under 42 U.S.C. § 300ff-11 et seq. The program is administered by the HRSA HIV/AIDS Bureau. Most Ryan White funding is distributed to eligible entities based on formulas that take into account living cases of HIV/AIDS. Funding for the individual grant programs (Parts A, B, C, D, and F) is shown in **Figure 1** and in **Table 1** at the end of this report.

P.L. 111-87 provided specific authorization levels for Parts A, B, C, D, and F for each fiscal year through FY2013, resulting in a four-year reauthorization for the Ryan White program. P.L. 111-87 required that the Secretary establish a national HIV/AIDS testing goal of 5 million tests annually through programs administered by HRSA and CDC. The Secretary is required to submit an annual report to Congress on the progress made in achieving the testing goal, including any barriers to meeting the goal, the amount of funding necessary to meet the goal, and the most cost-effective strategies for identifying individuals who are unaware of their HIV status. The Secretary is also required to review each of the programs and activities conducted by CDC as part of the Domestic HIV/AIDS Prevention Activities. The other provisions of P.L. 111-87 are discussed below in the sections of this report on the various parts of the Ryan White program.

The Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148, as amended) contains general provisions to increase access to health insurance and which, therefore, should

Figure 1. Ryan White Funding, FY2012

Total = \$2.4 billion



Source: HRSA, FY2013 Justification of Estimates for Appropriations Committees, p. 238-271.

¹ HRSA, *FY2013 Justification of Estimates for Appropriations Committees*, p. 238, <http://www.hrsa.gov/about/budget/budgetjustification2013.pdf>.

² P.L. 109-415 had reauthorized the Ryan White program through September 30, 2009. A provision at the end of P.L. 109-415 (§703) would have repealed the Ryan White program, Title XXVI of the PHS Act, as of the start of FY2010. The FY2010 Continuing Appropriations Resolution (Division B of P.L. 111-68), signed by President Obama on October 1, 2009, extended authority for the Ryan White program through October 31, 2009. The House Energy and Commerce Subcommittee on Health held a hearing in September 2009 on draft legislation that would reauthorize the Ryan White program. H.R. 3792 (Pallone), the Ryan White HIV/AIDS Treatment Extension Act of 2009, was introduced on October 13, 2009. The House Energy and Commerce approved H.R. 3792 on October 15, and a report was filed on October 20, 2009 (H.Rept. 111-305). The Ryan White HIV/AIDS Treatment Extension Act of 2009, S. 1793 (Harkin), was introduced on October 15 and passed the Senate by voice vote on October 19, 2009. The House passed S. 1793 on October 21, 2009, by a vote of 408-9. President Obama signed the legislation on October 30, 2009 (P.L. 111-87). P.L. 111-87 removed the sunset provision (§703 of P.L. 109-415).

increase coverage for people living with HIV/AIDS.³ They include prohibitions on the cancellation of coverage by an insurer due to a preexisting condition, elimination of lifetime caps on insurance benefits and annual limits on coverage, and eligibility for tax subsidies to assist low- and middle-income individuals in the purchase of coverage from health insurance exchanges. In addition, at state option, Medicaid eligibility will be broadened to include single adults, and ACA phases out the Medicare Part D so-called doughnut hole for HIV/AIDS individuals who are Medicare eligible.

The long-range impact of the health care law on HRSA's Ryan White program (meaning the replacement of health and treatment services provided under Ryan White with access to such services through health coverage via ACA) remains to be determined.

The Ryan White Program

Part A—Grants to Urban Areas

Part A provides funds to urban areas with high numbers of people living with HIV, as well as mid-sized cities that have emerging needs for assistance with their HIV-infected populations. The boundaries of the areas are based on the Metropolitan Statistical Areas of the U.S. Census Bureau and may range in size from a single city or county to multiple counties that cross state boundaries. According to HRSA, "more than 80% of Part A clients are people of color, and 30% are women."⁴

EMAs and TGAs

Part A provides funds to eligible metropolitan areas (EMAs) with a population of at least 50,000 that have had more than 2,000 reported AIDS cases in the prior five years. An EMA would stop being eligible if it failed for three consecutive years, to have: (a) a cumulative total of more than 2,000 reported cases of AIDS during the most recent five calendar years, and (b) a cumulative total of 3,000 or more *living* cases of AIDS as of December 31 of the most recent year.⁵ Part A currently provides grants to 24 EMAs.⁶

The 2006 reauthorization (P.L. 109-415) established a grant program for transitional grant areas (TGAs), defined as metropolitan areas with at least 1,000 but fewer than 2,000 cumulative AIDS

³ For more information on ACA in general, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind and Bernadette Fernandez, CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis; and CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

⁴ HRSA, *FY2013 Justification of Estimates for Appropriations Committees*, p. 250, <http://www.hrsa.gov/about/budget/budgetjustification2013.pdf>.

⁵ If an EMA no longer qualified as an EMA for FY2007, it was treated as a transitional grant area (TGA), even if it would not otherwise qualify as a TGA. Under the law prior to the 2006 reauthorization, a total of 51 EMAs received funding in FY2006. For FY2007 and FY2008, a total of 22 EMAs received funding; for FY2009, 24 EMAs received funding. Nassau-Suffolk, NY, and New Haven, CT, regained EMA status due to the results of a lawsuit filed by Nassau-Suffolk against HHS. Personal communication with HRSA Office of Legislation, and "County Executive Suozzi, Rep. Israel Declare Victory in Nassau-Suffolk Lawsuit to Save HIV/AIDS Funding," *US Fed News Service*, including *US State News*, April 28, 2008.

⁶ HRSA, *FY2013 Justification of Estimates for Appropriations Committees*, p. 249, <http://www.hrsa.gov/about/budget/budgetjustification2013.pdf>.

cases during the most recent five calendar years.⁷ Unless a TGA became an EMA, it would continue to be eligible as a TGA until it failed for three years to have (a) at least 1,000 but fewer than 2,000 cases of AIDS during the most recent five calendar years, and (b) 1,500 or more living cases of AIDS as of December 31 of the most recent calendar year. P.L. 111-87 permits a metropolitan area with a cumulative total of at least 1,400 but less than 1,500 living cases of AIDS to continue to be eligible as a TGA provided that not more than 5% of the TGA grant award is unobligated as of the end of the most recent fiscal year.⁸

Under P.L. 109-415, total amounts reserved for Part A EMAs and TGAs are adjusted based, in part, on the changing eligibility status of metropolitan areas.⁹ P.L. 111-87 contained provisions that modified the transfer of Part A grant funds to Part B for metropolitan areas that lose TGA eligibility. Specifically, if a metropolitan area were to lose TGA eligibility, the state containing the TGA would receive 75% of the TGA formula grant in the first year after the loss of TGA eligibility, 50% in the second year, and 25% in the third year. The remainder in each year is made available for Part B grants, as is the entire amount of the former TGA's formula grant in the fourth year after the loss of eligibility. Part A currently provides grants to 28 TGAs and "funds 4 states (California, New Jersey, New York and Puerto Rico) that have a city that was previously a TGA."¹⁰

Core Medical Services vs. Support Services

For each Part A grant, 75% of the funds must be spent on core medical services, defined as

- outpatient and ambulatory health services,
- AIDS Drug Assistance Program (ADAP) treatments and pharmaceutical assistance,
- oral health care,

⁷A total of 29 areas that had been EMAs prior to the 2006 reauthorization received funding as TGAs starting in FY2007 and five metropolitan areas received funding as TGAs in FY2007 that were not previously eligible as an EMA: Indianapolis, IN; Baton Rouge, LA; Charlotte, NC; Memphis, TN; and Nashville, TN. For FY2007 and FY2008, a total of 34 TGAs received funding. For FY2009, 32 TGAs received funding; two former TGAs, New Haven, CT, and Nassau-Suffolk, NY, received an EMA grant rather than a TGA grant.

⁸ HRSA identified six TGAs that might not have been eligible in FY2011 under P.L. 109-415 based on decreasing numbers of AIDS cases: Santa Rosa, CA; Vineland-Millville-Bridgeton, NJ; Ponce, PR; Middlesex-Somerset-Hunterdon, NJ; and Dutchess County, NY. "Section by Section Description of Ryan White HIV/AIDS Treatment Extension Act of 2009," p. 3, at http://energycommerce.house.gov/Press_111/20091013/Ryan_White_Section.pdf.

⁹ If a TGA qualified as an EMA in a subsequent year, the amount reserved for TGA grants would decrease by the amount of the grant made to the former TGA in the preceding FY and an equal amount would be reserved for EMA grants. If an EMA failed to meet the eligibility criteria for three consecutive years and thus ceased to be an EMA, in the first subsequent year, any amount reserved for EMAs would be reduced by the amount of the formula grant received in the preceding fiscal year by the metropolitan area that was no longer an EMA. If the former EMA qualified as a TGA, the amount reserved for TGA grants would increase by the amount of the reduction in EMA reserved funds. If the former EMA did not qualify as a TGA, the amount by which EMA reserved funds decreased would be equal to \$500,000 plus the amount of the formula grant received in the preceding fiscal year by the metropolitan area that was no longer an EMA; that money would be made available for Part B grants. Similarly, if a TGA failed to qualify as a TGA and did not qualify as an EMA, the amount reserved for TGA funds would be reduced by \$500,000 plus the amount of the formula portion of the TGA grant for the former TGA in the preceding fiscal year, and those funds would be made available for Part B grants.

¹⁰ In FY2011, Caguas, PR; Dutchess County, NY; Vineland, NJ; and Santa Rosa, CA did not receive TGA grants. Rather, Part A funds were awarded to Puerto Rico, New York, New Jersey, and California. These funds could be used to maintain services in these areas. HRSA, *FY2013 Justification of Estimates for Appropriations Committees*, pp. 249 and 252, <http://www.hrsa.gov/about/budget/budgetjustification2013.pdf>.

- early intervention services,
- health insurance premium and cost-sharing assistance,
- home health,
- medical nutrition therapy,
- hospice,
- home and community-based health services,
- mental health and substance abuse outpatient services, and
- medical case management.

The requirement may be waived if (1) there is no waiting list for receiving treatment (under the Part B ADAP program), and (2) core medical services were available to all individuals with HIV/AIDS who were eligible to receive such services under Part A.

The remaining 25% of funds may be used for support services, such as outreach services, medical transportation, language services, respite care for persons caring for individuals with HIV/AIDS, and referrals for health care and support services.

Formula Grants, Supplemental Grants, and Number of Living HIV/AIDS Cases

Two-thirds of the Part A appropriation is distributed through formula grants, and the remaining one-third is distributed via competitive supplemental grants awarded on the basis of need.¹¹ The awarding of supplemental Part A grants is based on weighting factors. Under P.L. 111-87, success in testing for HIV/AIDS and making individuals aware of their HIV status is counted as one-third in making such determinations.

CDC collects the statistics used in the Ryan White formula. In the past, some states reported their cases by name, while others used a code-based system to protect privacy.¹² CDC initially indicated its preference for name-based reporting in 1999 in order to avoid double counting. In 2005, the agency recommended that all jurisdictions transition to name-based reporting.

In contrast to EMA and TGA eligibility definitions that are based on cumulative AIDS cases, grant award amounts are based on living HIV/AIDS cases. Prior to the 2006 reauthorization, formula grants had been distributed to EMAs in proportion to an estimate of the number of living AIDS cases in each EMA.¹³ P.L. 109-415 changed the funding distribution, basing it on the number of living HIV *and* AIDS cases in each EMA *or* TGA for states that use a name-based HIV reporting system. The requirement for name-based HIV reporting in P.L. 106-345 and P.L. 109-415 influenced states to change from code-based reporting to name-based reporting.

P.L. 109-415 provided a transition period for states that did not have a fully mature name-based reporting system.¹⁴ P.L. 111-87 provided a continuation of the transition period for states that did

¹¹ The distribution under prior law (P.L. 106-345) was approximately fifty-fifty.

¹² Code-based reporting uses an alphanumeric code instead of a name.

¹³ The number of living AIDS cases was estimated from the number of reported AIDS cases over a 10-year period with weighting factors to reflect that not all reported cases were still alive. Under the 2000 reauthorization (P.L. 106-345), statistics on HIV cases could have been used in the Ryan White grant formulas as early as FY2005 if the Secretary of HHS found that HIV incidence data were sufficiently accurate and reliable. In June 2004, the Secretary determined that HIV case reporting was incomplete and could not be used to distribute the grants.

¹⁴ The 2000 reauthorization, P.L. 106-345, did not contain a transition period for states that were moving from code-

not have a fully mature name-based HIV reporting system.¹⁵ Under P.L. 111-87, these jurisdictions incur a 5% reduction in the number of non-AIDS HIV cases reported for the eligible area (to account for duplicate cases caused by code-based reporting) in making Part A grant determinations for fiscal years prior to FY2012 and a 6% reduction for FY2012. Beginning with FY2013, only living name-based cases of HIV/AIDS would be used in making Part A grant determinations. In addition, as was the case under P.L. 109-415, the amount of the formula grant in these areas may not exceed that of the preceding fiscal year by more than 5%.

For the purpose of determining Part A grant amounts, P.L. 111-87 would allow an increase of 3% in the number of living HIV/AIDS cases in an area for FY2010 through FY2012 if the area switched to name-based reporting in 2007 and had experienced a decrease in funding of more than 30% in FY2007 compared with FY2006.

Hold-Harmless Provision

P.L. 111-87 maintained a hold-harmless provision for Part A, protecting grantees from large decreases in funding.¹⁶ Formula grant amounts for FY2010 were equal to 95% of funding in FY2009, funding in FY2011 and FY2012 are 100% of FY2010, and funding in FY2013 will be an amount equal to 92.5% of FY2012. The hold-harmless provision is funded with money that would have been distributed through Part A supplemental grants. If in a given year the supplemental funds are insufficient to fund the hold-harmless in a year, the Secretary would reduce on a pro rata basis the grant amount for each EMA other than those eligible for the hold-harmless provision, though the reduction would not be allowed to result in any additional EMA becoming eligible for the hold-harmless provision.

In September 2009, GAO released a report on the impact of several funding provisions on Ryan White grant awards.¹⁷ One of the provisions the 2009 GAO report focused on was the distribution of hold-harmless funding among Part A EMAs. GAO found that 17 of 24 (71%) EMAs received hold-harmless funding in FY2009, compared with 21 of 51 (41%) EMAs in FY2004.¹⁸ The total amount of hold-harmless funding distributed among the EMAs was larger in FY2009 (\$24,836,500) than in FY2004 (\$8,033,563).¹⁹ GAO looked at the amount of funding (including

based to name-based HIV reporting as recommended by the CDC. P.L. 109-415 provided a three-year transition period for qualifying areas. For purposes of the Part A formula, states without a sufficiently accurate and reliable name-based reporting system had a reduction of 5% in the number of non-AIDS HIV cases reported for an eligible area to account for duplicate cases. P.L. 109-415 identified 33 states and 2 territories that had a sufficiently accurate and reliable names-based reporting system as of December 31, 2005.

¹⁵ California, Hawaii, Illinois, Maryland, Massachusetts, Oregon, Rhode Island and the District of Columbia did not have fully mature name-based HIV reporting systems. "Section by Section Description of Ryan White HIV/AIDS Treatment Extension Act of 2009," p. 2, at http://energycommerce.house.gov/Press_111/20091013/Ryan_White_Section.pdf. In addition, a September 18, 2009 GAO report identified three territories that had not begun collecting name-based HIV case counts.

¹⁶ The 1996, 2000 and 2006 reauthorizations also provided a hold harmless. In 2006 the hold harmless was extended for three years for EMAs that received a hold harmless amount in FY2006. For FY2007, an EMA that had received a hold harmless amount in FY2006 would receive not less than 95% of a grant amount equal to what the EMA would have gotten in FY2006 (including the hold harmless) if the FY2006 formula had distributed two-thirds of the FY2006 appropriation. For FY2008 and FY2009, under the language of P.L. 109-415 the EMA would receive not less than 100% of the grant amount for FY2007. The hold harmless does not apply to TGAs.

¹⁷ U.S. Government Accountability Office, *Ryan White CARE Act: Effects of Certain Funding Provisions on Grant Awards*, GAO-09-894, September 18, 2009, <http://www.gao.gov/new.items/d09894.pdf>.

¹⁸ In the 2006 reauthorization, the number of EMAs was reduced from 51 to 24, with the remainder being classified as TGAs. TGAs are not eligible for hold-harmless funding.

¹⁹ Funding for FY2009 does not include amounts resulting from the stop-loss provision in the FY2009 appropriation

hold-harmless) per HIV/AIDS case, which for FY2009 ranged from \$645 in San Diego to \$854 in San Francisco; for FY2004, the amount of funding per case ranged from \$1,221 in most EMAs to \$2,241 in San Francisco. GAO determined that the smaller funding range in FY2009 “resulted from San Francisco receiving less hold-harmless funding in FY2009 than in FY2004. In both years, San Francisco received the most hold-harmless funding per case. However, in FY2009, San Francisco received \$208 in hold-harmless per case while in FY2004 it received \$1,020 in hold-harmless funding per case.”²⁰

GAO also noted that “hold-harmless funding accounted for a larger percentage of San Francisco’s total base funding than it did for any other EMA in FY2009 and FY2004, but the percentage was smaller in FY2009 (24%) than in FY2004 (46%).”²¹ However, GAO found that for FY2009, “because of its hold-harmless funding, San Francisco, which had 17,173 HIV/AIDS cases, received a base grant equivalent to what an EMA with approximately 22,713 cases (32% more) would have received without hold-harmless funding.”²² GAO stated that “a significant portion of the difference in funding per case between San Francisco and the other EMAs results from how the San Francisco case counts are determined. The San Francisco EMA continues to be the only metropolitan area whose formula funding is based on both living and deceased AIDS cases.”²³ GAO explains that this is due to the hold-harmless calculations that in part, for San Francisco alone, refer back to case counts in FY1995 that included both living and deceased AIDS cases.

The hold-harmless provision is funded with money that would have been distributed through Part A supplemental grants. Without the hold-harmless provision, in FY2009 most Part A grantees would have received more funding. GAO notes that “although 17 EMAs received hold-harmless funding in FY2009, only 7 (New York, San Francisco, San Juan, West Palm Beach, Newark, New Haven, and Nassau-Suffolk) received more funding because of the hold-harmless provision than they would have received through supplemental grants in the absence of the hold-harmless provision.”²⁴

Stop-Loss Provisions

Like the hold-harmless provision, stop-loss provisions in appropriations bills have had an impact on the funding of Ryan White grants. A stop-loss provision in the FY2008 Consolidated Appropriations Act (H.R. 2764, P.L. 110-161) affected the FY2008 funding of Ryan White Part A grants to metropolitan areas by setting aside some FY2008 funds to make up for losses in FY2007 grants to certain areas.²⁵ A similar stop-loss provision in the FY2009 Omnibus Appropriations Act (H.R. 1105, P.L. 111-8) affected the FY2009 funding of Ryan White Part A grants to metropolitan

act, P.L. 111-8. For an explanation of the stop-loss provision, see the “Stop-Loss Provisions” section of this report.

²⁰ GAO, *Ryan White CARE Act: Effects of Certain Funding Provisions on Grant Awards*, pp. 18-19.

²¹ *Ibid.*, p. 20.

²² *Ibid.*, p. 22.

²³ *Ibid.*

²⁴ *Ibid.*, p. 23.

²⁵ The provision in P.L. 110-161 ensured that an area’s total funding under Part A for FY2007 was not less than 86.6% of the amount of the area’s total funding under Part A for FY2006. See the October 5, 2007 Government Accountability Office (GAO) report (GAO-08-137R), at <http://www.gao.gov/new.items/d08137r.pdf>. GAO analyzed the impact of a previously proposed hold harmless provision in an FY2008 Labor-HHS appropriations bill (H.R. 3043) that was not enacted. See also Shawn Zeller, “The AIDS Cash Clash,” *CQ Weekly*, July 30, 2007, p. 2248.

areas.²⁶ The FY2009 provision set aside \$10.853 million, which was divided among five EMAs and seven TGAs; 58% of the set-aside went to the San Francisco EMA.²⁷

The stop-loss provision in the Consolidated Appropriations Act, 2010 (P.L. 111-117), set aside \$6.021 million for increasing supplemental grants for FY2010 to EMAs and TGAs “to ensure that an area’s total funding under [part A] for FY2009, together with the amount of this additional funding, is not less than 92.4% of the amount of such area’s total funding under part A for FY2006.” This is the same as language contained in the House Labor-HHS Appropriations bill for FY2010, (H.R. 3293).²⁸ An August 3, 2009, GAO analysis of the stop-loss provision in the House version of H.R. 3293 indicated that two EMAs and four TGAs would receive funds; 85% of the stop-loss funds would go to San Francisco, CA.²⁹

A GAO analysis of applying the FY2010 stop-loss provision on FY2011 Ryan White Part A funding for EMAs and TGAs found that one EMA and three TGAs would receive stop-loss funds; 88% of the stop-loss funds would go to the San Francisco EMA.³⁰

Planning Councils

Part A grants are made to the chief elected official of the city or county in the EMA or TGA that administers the health agency providing services to the greatest number of persons with HIV. The official must establish an HIV Health Services Planning Council, which sets priorities for care delivery according to federal guidelines. Planning Councils are not mandatory for TGAs, unless the TGA was an EMA in FY2006. The council may not be directly involved in the administration of any Part A grant. Membership of the council must reflect the ethnic and racial make-up of the local HIV epidemic.

P.L. 111-87 required the Part A Planning Councils to develop a strategy for identifying individuals with HIV/AIDS who do not know their HIV status, making them aware of their status and connecting them with health care and support services. Particular attention is given to “reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities.”

²⁶ The provision in P.L. 111-8 ensured that an EMA’s total funding under Part A for FY2008 was not less than 93.7% of the amount of the EMA’s total funding under Part A for FY2006, and that a TGA’s funding under Part A for FY2008 was not less than 88.7% of the amount of the TGA’s total funding under Part A for FY2006. A March 6, 2009, GAO report (GAO-09-472R) analyzed the impact of the stop-loss provision in the FY2009 Omnibus Appropriations Act (H.R. 1105) as passed by the House.

²⁷ See <http://newsroom.hrsa.gov/releases/2009/parta.htm>.

²⁸ The House Appropriations Committee report on H.R. 3293, H.Rept. 111-220, stated “when allocating FY2010 supplemental funds under Part A ..., the Committee urges HRSA to provide additional increases to jurisdictions that have experienced cuts in their total awards relative to the amount awarded in FY2006.” The Senate Appropriations Committee report (S.Rept. 111-66) on H.R. 3293 indicated that the Senate amount for Part A is \$8 million less than the President’s request and \$16 million less than the House. The Senate report stated, “The Committee notes that the FY2009 comparable level included a provision directing funds to particular metropolitan areas facing dramatic cuts as a result of the changes to the Ryan White formula. The Committee has not continued this provision in FY2010.”

²⁹ U.S. Government Accountability Office, *Ryan White CARE Act: Estimated Effect of Proposed Stop-Loss Provision in H.R. 3293 on Urban Areas*, GAO-09-947R, August 3, 2009, <http://www.gao.gov/new.items/d09947r.pdf>.

³⁰ U.S. Government Accountability Office, *Ryan White CARE Act: Estimated Effect of Continued Application of the Fiscal Year 2010 Stop-Loss Provision on 2011 Funding of Urban Areas*, GAO-11-405R, February 18, 2011, <http://www.gao.gov/search?q=GAO-11-405R>.

Unexpended Funds

The 2006 reauthorization introduced restrictions on the use of unexpended funds. Starting in FY2007, if an eligible area did not obligate all *supplemental* grant funds within one year of receiving the award, the eligible area is required to return any unobligated funds. Similarly, starting in FY2007, if an eligible area did not obligate all *formula* grant funds within one year of receiving the award, the eligible area is required to return any unobligated funds. However, the eligible area may request a waiver of the cancellation of formula grant funds, explaining how the eligible area intends to spend the funds. If the waiver is approved, the eligible area will have one additional year in which to spend the funds. This is called the carryover year. If the funds are not spent by the end of the carryover year, the eligible area will be required to return the unexpended funds.

Regardless of whether the waiver for carryover was granted, under the 2006 reauthorization the eligible area's formula grant funds would be reduced for the following year by an amount equal to the unobligated balance; the reduction would not be taken into account in applying the hold-harmless provision for the subsequent fiscal year and the grantee is ineligible for supplemental grants.³¹ However, the 2009 reauthorization stipulated that the amount of the reduction would not include any unobligated balance that was approved by HRSA for carryover, and the reduction in formula grant funds does not apply if the unobligated balance is 5% or less.³² Any returned grant funds are additional amounts available for supplemental grants, subject to both (1) the mandatory transfer of funds from Part A to Part B when a Part A area loses eligibility, and (2) the hold-harmless provision for Part A formula grants.

Part B—Grants to States

Part B provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and five jurisdictions in the Pacific. Grant funds can be used for drug treatments, home and community-based health care, and support services or health insurance coverage for low-income persons through Health Insurance Continuation Programs. Currently about two-thirds of Part B funding is set aside by Congress for the AIDS Drug Assistance Programs (ADAPs). ADAPs provide drug treatments for individuals with HIV who cannot afford to pay for drugs and have limited or no coverage from private insurance, Medicaid, or Medicare Part D. ADAP funds also may be used to purchase health insurance for eligible clients or to pay for services that enhance access, adherence, and monitoring of drug treatments.

P.L. 111-87 required that the Part B grant application provide a comprehensive plan for the identification of individuals with HIV/AIDS who are unaware of their HIV/AIDS status and enable such individuals access to medical treatment for HIV/AIDS. The comprehensive plan must include efforts to remove any legal barriers, including states laws and regulations, to routine testing.

As is the case for Part A grants, 75% of Part B funds must be spent on core medical services and 25% may be spent on support services (defined above in “Core Medical Services vs. Support Services”).

³¹ P.L. 109-415.

³² Under P.L. 109-415, the reduction in formula grant funds did not apply if the unobligated balance was 2% or less.

Formula Grants and Number of Living HIV/AIDS Cases

Two-thirds of the Part B appropriation (non-ADAP) is used for the Part B base awards and one-third is reserved for a supplemental grant program (see “Supplemental Grants and Hold-Harmless Provision”). The Part B base award formula is based on three factors: (1) 75% of the award is based on the state’s proportion of the nation’s HIV/AIDS cases; (2) 20% is based on the state’s proportion of HIV/AIDS cases outside Part A-funded areas (EMAs and TGAs); and (3) 5% is based on the state’s proportion of HIV/AIDS cases in states with no Part A funding.³³

Prior to the 2006 reauthorization, formula grants had been distributed to states in proportion to an estimate of the number of living AIDS cases in each state.³⁴ As a result of P.L. 109-415, funding distribution is now based on the number of living HIV and AIDS cases for states that use a name-based HIV reporting system. The requirement for name-based HIV reporting influenced states to change from code-based reporting to name-based reporting. P.L. 109-415 provided a transition period for states that did not have a fully mature name-based reporting system.

According to the September 2009 GAO report, 47 of the 59 Part B grantees had HRSA use their name-based HIV case counts to determine FY2009 formula funding, and the remaining 12 grantees had HRSA use code-based HIV case counts.³⁵ Of the 12 grantees, 7 were collecting name-based HIV case counts as of December 31, 2007, and 5 were not.³⁶ GAO indicated that “each of the 12 grantees could require 4 years from the date they began collecting name-based HIV case counts for such reporting systems to be considered reliable and accurate. However, grantees can determine that their reporting systems are accurate and reliable in less than 4 years.”³⁷ If the transition period for states that do not have a fully mature name-based HIV reporting system was not extended, some grantees might not receive funding in proportion to their number of HIV/AIDS cases, “which is the intended basis of the formula grant.”³⁸

P.L. 111-87 provided a continuation of the transition period for states that did not have a fully mature name-based HIV reporting system. Under P.L. 111-87, these jurisdictions incur a 5%

³³ The formula attempts to correct for a problem under a previous formula: specifically, states with EMAs received a larger amount of money, per case, than states without an EMA. U.S. Government Accountability Office, *Ryan White CARE Act: Factors that Impact HIV and AIDS Funding and Client Coverage*, GAO-05-841T, June 2005, <http://www.gao.gov/new.items/d05841t.pdf>

³⁴ The number of living AIDS cases was estimated from the number of reported AIDS cases over a 10-year period with weighting factors to reflect that not all reported cases were still alive. Under the 2000 reauthorization (P.L. 106-345), statistics on HIV cases would have been used in the Ryan White grant formulas as early as FY2005 if the Secretary of HHS found that HIV incidence data were sufficiently accurate and reliable. In June 2004, the Secretary determined that HIV case reporting was incomplete and could not be used to distribute the grants. Under P.L. 106-345 HIV case data would have been used for determining FY2007 grant amounts. However, P.L. 106-345 did not contain a transition period for states that were moving to name-based HIV reporting, as recommended by the CDC. P.L. 109-415 had a three-year transition period for qualifying areas.

³⁵ U.S. Government Accountability Office, *Ryan White CARE Act: Effects of Certain Funding Provisions on Grant Awards*, GAO-09-894, September 18, 2009, <http://www.gao.gov/new.items/d09894.pdf>.

³⁶ Ibid., p. 14. The seven grantees are as follows: CA, DC, IL, MD, MA, OR, RI. All but MD could have had HRSA use their name-based HIV case counts to determine formula funding but instead had HRSA use their code-based counts. MD’s name-based HIV reporting system had not been determined to be operational and, therefore, did not have that option. The 5 grantees are as follows: HI, VT, the Federated States of Micronesia, Palau, and the Republic of the Marshall Islands. HI and VT transitioned to name-based reporting in 2008; the remaining 3 had not begun collecting name-based HIV case counts.

³⁷ Ibid., p. 14. According to the GAO report, eight grantees, CT, DE, KY, ME, MT, NH, PA, and WA, with systems less than four years old determined that their name-based HIV reporting systems were accurate and reliable such that case counts from these systems were used by HRSA to determine FY2009 funding.

³⁸ Ibid., p. 16.

reduction in the number of non-AIDS HIV cases reported for the eligible area (to account for duplicate cases caused by code-based reporting) in making Part B grant determinations for fiscal years prior to FY2012 and a 6% reduction for FY2012. Beginning with FY2013, only living name-based cases of HIV/AIDS would be used in making Part B grant determinations.

For the purpose of determining Part B grant amounts, P.L. 111-87 would allow an increase of 3% in the number of living HIV/AIDS cases in an area for FY2010 through FY2012 if the area switched to name-based reporting in 2007 *and* had experienced a decrease in funding of more than 30% in FY2007 compared with FY2006.

Supplemental Grants and Hold-Harmless Provision

One-third of the Part B appropriation (non-ADAP) is reserved for a supplemental grant program created by P.L. 109-415. Eligible states must have a demonstrated need for supplemental financial assistance and no cancelled grant funds or waivers permitting carryover of funds (see “Unexpended Funds”). Priority in making supplemental grants is given to states with a decline in funding under Part B due to the changes in the distribution formula. Supplemental grant funds must be used for core medical services. Not later than 45 days after awarding supplemental funds under Part B, HRSA must submit a report to Congress concerning such funds.

P.L. 111-87 maintains a hold-harmless provision for Part B.³⁹ Formula grants for FY2010 would be an amount equal to 95% of funding in FY2009, funding in FY2011 and FY2012 would be an amount equal to 100% of FY2010, and funding in FY2013 would be an amount equal to 92.5% of FY2012. The hold-harmless provision is funded by reducing the amount reserved for the Part B supplemental grant program and by any unobligated funds repaid by the states (see “Unexpended Funds”). If there are insufficient funds for the hold-harmless provision, then current law allows for a pro rata reduction of all Part B state grants, excepting those states receiving hold-harmless funds. However, such reductions will not be made in an amount that results in other states becoming eligible for the hold-harmless.

Unexpended Funds

Starting in FY2007, states were required to obligate grant funds by the end of the grant year for Part B formula grants, supplemental grants, emerging communities grants, ADAP grants, and supplemental ADAP grants. For supplemental ADAP grants, supplemental grants, and emerging communities grants, if there is an unobligated balance at the end of the grant year, the state must return the amount and the funds will be used for additional supplemental grants (subject to the hold-harmless provision).

For Part B formula grants and ADAP grants, if there is an unobligated balance the state must either return the unexpended funds or apply for a waiver to use the funds in the next year. If the waiver is approved, the funds would be available for one more year, called the carryover year. If the state fails to use the funds in the carryover year, the state must return the funds, which will be used for supplemental grants (subject to the hold-harmless provision).

However, for states with an unobligated balance for their Part B formula grant or an ADAP grant, the amount of the grant for the next year would be reduced by the amount of the unobligated

³⁹ A hold-harmless provision protects grantees from large decreases in funding. Under the P.L. 109-415 hold-harmless provision, for FY2007, a state could not receive less than 95% of the grant amount received in FY2006. For FY2008 and FY2009, a state could not receive less than 100% of the FY2007 grant amount.

balance and the state would not be eligible for supplemental grants in the following year.⁴⁰ The 2009 reauthorization allowed that the amount of the reduction would not include any unobligated balance that was approved by HRSA for carryover; if the amount of the unobligated balance was 5% or less, the grant reduction would not apply.⁴¹ The funds from grant reduction are used for supplemental grants (subject to the hold-harmless provision).

Drug rebates are received by Part B grantees from pharmaceutical manufacturers following the purchase of drugs for the ADAP program. There is a federal requirement that drug rebate funds be spent before federal funds are obligated. Because rebates may be received by the state late in the year, this requirement may result in some states incurring an unobligated balance penalty. Under P.L. 111-87, if an expenditure of ADAP rebate funds triggered a penalty, the Secretary may deem the state's unobligated balance to be reduced by the amount of the rebate. Any unobligated amount returned to the Secretary would be used for ADAP supplemental grants or Part B supplemental grants.

A September 2009 GAO report found that nine states and seven territories received reduced Part B grant amounts in the 2009 grant year because they had unobligated balances over 2% in the 2007 grant year.⁴² "Part B base funding penalties ranged from \$6,433 in Palau to \$1,493,935 in Ohio. ADAP base funding penalties ranged from \$26,233 in Maine to \$12,670,248 in Pennsylvania."⁴³ According to GAO, grantees "had varying reasons for their unobligated balances, some of which they said were beyond their control."⁴⁴ Almost half of the grantees interviewed by GAO said the 2% threshold was too low, and some suggested that 5% would be more reasonable. However, GAO noted that "only 2 of the 16 Part B grantees that received penalties for unobligated balances had unobligated balances of less than 5%."⁴⁵ The GAO reported that both grantees and HRSA stated that a requirement to spend drug rebate funds before obligating federal funds makes it more difficult to avoid unobligated balances. According to GAO, HRSA tried to address this problem by asking HHS for an exemption from the relevant regulations for grantees using drug rebates, but the request was denied.⁴⁶

Emerging Community Grants

The grant program for emerging communities defines such communities as metropolitan areas with cumulative total of at least 500 and fewer than 1,000 reported cases of AIDS during the most recent five calendar years. The metropolitan area continues as an emerging community until the metropolitan area fails for three consecutive fiscal years (1) to have the required number of AIDS cases; and (2) to have a cumulative total of 750 or more living cases of AIDS as of December 31 of the most recent calendar year. The grant amount is determined by the amount set aside by the Secretary (authorized at \$5 million) and by the proportion of the total number of living cases of

⁴⁰ P.L. 109-415

⁴¹ Under P.L. 109-415, the reduction in formula grant funds did not apply if the unobligated balance was 2% or less.

⁴² U.S. Government Accountability Office, *Ryan White CARE Act: Effects of Certain Funding Provisions on Grant Awards*, GAO-09-894, September 18, 2009, p. 24, <http://www.gao.gov/new.items/d09894.pdf>. The 9 states were as follows: AZ, AR, CO, DE, ID, ME, NE, OH, and PA. The 7 territories were as follows: American Samoa, Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, Palau, the Republic of Marshall Islands, and the U.S. Virgin Islands. Part A grantees did not have unobligated balances over 2%.

⁴³ Ibid., p. 25.

⁴⁴ Ibid., p. 27.

⁴⁵ Ibid., p. 29.

⁴⁶ Ibid., pp. 30-31.

HIV/AIDS in emerging communities in the state to the total number of living cases of HIV/AIDS in emerging communities in the United States.

ADAP

In 2010, about 46% of HIV positive people in care in the United States received their medications through State ADAPs.⁴⁷ ADAP funds are distributed via a formula based on each state's proportion of living HIV and AIDS cases.⁴⁸ Under P.L. 111-87 the program provides a continuation of the transition period for states that do not have a fully mature name-based HIV reporting system. Under P.L. 111-87, these jurisdictions incur a 5% reduction in the number of non-AIDS HIV cases reported for the eligible area (to account for duplicate cases caused by code-based reporting) in making ADAP grant determinations for fiscal years prior to FY2012 and a 6% reduction for FY2012. Beginning with FY2013, only living name-based cases of HIV/AIDS would be used in making ADAP grant determinations. The same hold-harmless provision that applies to other Part A and Part B formula grants also applies to the ADAP formula grants.⁴⁹

Five percent of the ADAP appropriation is set aside for ADAP supplemental grants. States are eligible for these grants if they demonstrate a severe need to increase the availability of HIV/AIDS drugs. There is a state-match requirement (\$1 state for every \$4 federal) for ADAP supplemental grants that may be waived under certain circumstances. The 2006 reauthorization established a formulary, a list of HIV/AIDS therapeutics that all ADAPs must provide. The list is based on the clinical practice guidelines for use of HIV/AIDS drugs issued by HHS.⁵⁰

According to a January 2012 report produced by the National Alliance of State and Territorial AIDS Directors (NASTAD), in FY2011 federal ADAP funds provided 43% of the national ADAP budget, state contributions provided 16%, and drug rebates provided another 33%.⁵¹ Many states have had to implement cost containment measures, such as waiting lists, because of insufficient ADAP funds.⁵² As of September 13, 2012, NASTAD reports that a total of 88 people are on

⁴⁷ HRSA, *FY2013 Justification of Estimates for Appropriations Committees*, p. 247, <http://www.hrsa.gov/about/budget/budgetjustification2013.pdf>.

⁴⁸ ADAP operates in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the Republic of the Marshall Islands.

⁴⁹ Grants for FY2010 would be an amount equal to 95% of funding in FY2009, funding in FY2011 and FY2012 would be an amount equal to 100% of FY2010, and funding in FY2013 would be an amount equal to 92.5% of FY2012.

⁵⁰ Guidelines are found at <http://aidsinfo.nih.gov/Guidelines/Default.aspx?MenuItem=Guidelines>.

⁵¹ The remaining 8% consisted of funds from Part B ADAP Supplemental (2%), Part B Base grants (1%), Part B Supplemental Contribution Directed to ADAP (< 1%), Part A contributions (1%), ADAP emergency funding (2%), and other state or federal funds (1%). NASTAD, *National ADAP Monitoring Project Annual Report Module One*, January 2012, p. 16, at <http://www.nastad.org>.

⁵² The George W. Bush Administration and Barack Obama Administration have provided supplemental ADAP grants in to help alleviate this problem. On September 18, 2007, the George W. Bush Administration announced supplemental ADAP grants totaling \$39.5 million to 14 states (Alabama, Alaska, Georgia, Indiana, Iowa, Montana, North Carolina, Oklahoma, Oregon, South Carolina, Texas, Utah, Virginia, and Wisconsin), the Virgin Islands, and Puerto Rico. On June 23, 2004, the George W. Bush Administration announced what it described as a one-time \$20 million initiative for 10 states with ADAP waiting lists (Alabama, Alaska, Colorado, Idaho, Iowa, Kentucky, Montana, North Carolina, South Dakota, and West Virginia). In July 2010 HHS Secretary Kathleen Sebelius announced the reallocation of \$25 million in funds from dozens of programs throughout HHS for ADAP. The additional funds were targeted for states with ADAP waiting lists or other cost containment strategies. On July 19, 2012, HHS Secretary Kathleen Sebelius announced that \$69 million will be sent to 23 states (Alabama, Alaska, Arizona, California, Colorado, Florida, Georgia, Idaho, Illinois, Iowa, Kentucky, Louisiana, Montana, Nebraska, New Jersey, North Carolina, North Dakota, South Dakota, Tennessee, Utah, Virginia, Washington, and Wisconsin) Puerto Rico and the Virgin Islands through Ryan White ADAP to eliminate waiting lists.

waiting lists in Florida, Louisiana, and South Dakota.⁵³ States have also lowered income eligibility criteria, reduced their formulary, capped enrollment, instituted a monthly or annual expenditure cap, and instituted client cost sharing as well as other cost-containment strategies.⁵⁴

The January 2012 NASTAD report and the HRSA Ryan White Program budget justification for FY2013 both note that a number of factors have strained ADAPs in recent years.

NASTAD: Increases in ADAP client utilization and progression to more costly drug regimens, while likely resulting in important health outcomes for people living with HIV/AIDS, have led to considerable fiscal stress for many ADAPs, unable to keep pace with those demands. As a result of the nation's continued economic crisis, more Americans living with HIV are relying on public health safety net programs, including ADAP, as a vital resource for medications. This increasing demand for services, coupled with minimal increases in federal appropriations and fluctuations in state funding, heightened national efforts focused on HIV testing and linkages into care, high drug costs, and new HIV treatment guidelines calling for earlier therapeutic treatments have caused fiscal challenges for many ADAPs as they provide services to those in need.⁵⁵

HRSA Ryan White Program: Over the past three years, the convergence of several factors has resulted in significant budget challenges for the Part B program. These include the economic downturn, a national HIV testing initiative that has brought more people infected with HIV into care, federal recommendations for earlier treatment of HIV, and continued improvements in HIV care and treatment that has prolonged survival, increasing HIV prevalence.⁵⁶

Part C—Early Intervention Services

Part C grants provide medical services to underserved and uninsured people living with HIV/AIDS in rural and frontier communities. Part C “provides direct grants to 349 community and faith based primary health clinics and public health providers in 49 states, Puerto Rico, the District of Columbia and the U.S. Virgin Islands.”⁵⁷ Under current law, 75% of a Part C grant must be used for core medical services, and not less than 50% of a grant must be used for early intervention services. Part C grants are awarded to federally qualified health centers, family planning clinics, hemophilia centers, rural health clinics, Indian Health Service facilities, and certain health facilities and community-based organizations that provide early intervention services to people infected with HIV/AIDS through intravenous drug use. Part C services include counseling, HIV testing, referrals, clinical and diagnostic services regarding HIV/AIDS, and drug treatments under ADAP.

Part D—Women, Infants, Children and Youth

Part D provides grants to public and nonprofit entities for family-centered care for women, infants, children, and youth with HIV/AIDS. Such individuals are provided outpatient health care, case management, referrals, and other services to enable participation in the program including

⁵³ NASTAD, ADAP Watch, September 14, 2012, at <http://www.nastad.org>.

⁵⁴ Ibid.

⁵⁵ NASTAD, National ADAP Monitoring Project Annual Report Module One, January 2012, p. 3, at <http://www.nastad.org>.

⁵⁶ HRSA, *FY2013 Justification of Estimates for Appropriations Committees*, p. 255, <http://www.hrsa.gov/about/budget/budgetjustification2013.pdf>.

⁵⁷ Ibid., p. 260.

services designed to recruit and retain youth with HIV. Grantees must coordinate with programs promoting the reduction and elimination of risk of HIV/AIDS for youth.

The 2006 reauthorization required that, starting in FY2007, administrative expenses must be no more than 10% of the Part D grant, and GAO was directed to conduct an evaluation of Part D spending. GAO released its report in December 2008.⁵⁸ According to GAO, a majority of the Part D grantees reported that they have not made changes to client services in response to the administrative expense cap. However, a majority of Part D grantees reported that the cap has had a negative effect on their Part D program because clinical staff must now perform administrative tasks. Also, about half of grantees reported that not all of their Part D administrative expenses were covered by the 10% allowance. In FY2009, HRSA required that Part D grantees provide more detailed budget information.

P.L. 111-87 clarifies that Part D should be the payer of last resort when Part D clients have access to other forms of health care coverage, such as Medicaid and the Children's Health Insurance Program. P.L. 111-87 also ensures that memoranda of understanding can be used by certain Part D providers to ensure clients have access to primary care.

Part E

In the past, Part E authorized grants for emergency response employees and established procedures for notifications of infectious diseases exposure; Part E was never funded. The 2006 reauthorization (P.L. 109-415) deleted the sections of Part E on emergency response and inserted into Part E several sections, with some text changes, from Part D (on coordination, audits, definitions, and a prohibition on promotion of intravenous drug use or sexual activity) and two new sections on public health emergencies and certain privacy protections.

P.L. 109-415 inadvertently deleted language on "procedures for the notification of occupational infectious diseases exposure" from Part E of Ryan White. This was a matter of some concern for the emergency response community and reinstatement of the relevant language was requested.⁵⁹ P.L. 111-87 reinserted the deleted language on "procedures for the notification of occupational infectious diseases exposure" into a new Part G of Title XXVI of the PHS Act, including a change from the original language that would permit the Secretary to suspend the requirements in a public health emergency.

Part F—Demonstration and Training

Part F provides support for the AIDS Dental Reimbursement (ADR) Program, the Community-Based Dental Partnership Program, the AIDS Education and Training Centers (AETCs), and the Special Projects of National Significance (SPNS) Program.⁶⁰ The ADR program reimburses

⁵⁸ U.S. Government Accountability Office, *Ryan White CARE Act: First-Year Experiences under the Part D Administrative Expense Cap*, GAO-09-140, December 19, 2008, <http://www.gao.gov/products/GAO-09-140>.

⁵⁹ Katherine West, "Ryan White Notification Law for Emergency Response Employees Deleted: 10 Reasons Why We Need it Back," *EMS Magazine*, October 2008, at [http://www.emsresponder.com/print/EMS-Magazine/Ryan-White-Notification-Law-for-Emergency-Response-Employees-Deleted—10-Reasons-Why-We-Need-It-Back/1\\$8394](http://www.emsresponder.com/print/EMS-Magazine/Ryan-White-Notification-Law-for-Emergency-Response-Employees-Deleted—10-Reasons-Why-We-Need-It-Back/1$8394); James R. Cross, JD, "Ryan White Notification Law Repealed: The Deletion of Emergency Response Provisions Demands Attention," *Journal of Emergency Medical Services*, March 2008, p. 136-137; and National Association of State EMS Officials, "NASEMSO Issue Brief on the Repeal of Emergency-Response Provisions Contained in the Ryan White CARE Act," March 2008, at <http://www.nasemsd.org/Advocacy/PositionsResolutions/documents/RyanWhiteIssueBrief032508.pdf>.

⁶⁰ Both the dental and the AETC programs were transferred legislatively from Title VII of the PHS Act.

dental schools for their treatment of HIV/AIDS patients. The AETC program provides specialized clinical education and consultation for health providers on HIV transmission, treatment, and prevention.⁶¹

The SPNS program awards grants to entities eligible for funding under Parts A, B, C, and D to (1) quickly respond to emerging needs of persons receiving assistance under this title, and (2) develop a standard electronic client information data system to improve grantee reporting of client-level data to the Secretary. The 2006 reauthorization provided new criteria for making SPNS grant awards that are focused on obtaining client-level data to create a Severity of Need Index (SONI); creating and maintaining a safe, secure, and reliable qualified health information technology system; or newly emerging needs of persons receiving assistance under this title.

Under statute, the SPNS program is to be funded, up to \$25 million, from amounts appropriated for Parts A, B, C, and D; this was not changed by reauthorization. However, beginning in FY2003, each Labor-HHS appropriations bill has provided \$25 million for the SPNS program via a funding mechanism known as the “PHS evaluation tap.”⁶² The \$25 million is divided, roughly proportionately, among Parts A, B, C, and D, which then make the individual SPNS grant awards.

P.L. 109-415 codified the Minority AIDS Initiative (MAI) as part of the Ryan White program under Part F of Title XXVI of the PHS Act.⁶³ Under P.L. 109-415, MAI provided funding for competitive grants under Parts A, B, C, D, and F that evaluate and address the disproportionate impact of HIV/AIDS on racial and ethnic minorities.

P.L. 111-87 directs HRSA to develop a formula for awarding MAI grants under Part A and Part B “that ensures that funding is provided based on the distribution of populations disproportionately impacted by HIV/AIDS.”⁶⁴ The law directs HRSA to synchronize the schedule of application submissions and funding of MAI grants with the schedule of the corresponding Ryan White Part (A, B, C, D, or F).

P.L. 111-87 requires GAO to provide a report for Congress within one year of enactment that describes MAI activities across HHS. The GAO report would “include a history of program activities, a description of activities conducted, people served and types of grantees funded.” The report would “collect and describe best practices in community outreach and capacity-building of community based organizations serving the communities that are disproportionately affected by HIV/AIDS.” Within six months of publication of the GAO report, P.L. 111-87 required that HHS submit to Congress a departmental plan for using MAI funds in all the relevant agencies to build capacity, taking into consideration the best practices described in the GAO report.

⁶¹ In September 2010, HRSA announced awards for two new AETCs. U.S. Department of Health and Human Services, “HHS Awards \$3.5 Million to Expand HIV/AIDS Care Capacity for Minorities,” press release, September 1, 2010, <http://www.hrsa.gov/about/news/pressreleases/100901hhsawards35milliontoexpandhivaidscapecapacityforminorities.html>.

⁶² The tap, authorized under §241 of the PHS Act, transfers money among PHS agencies for particular activities as specified by the appropriators.

⁶³ The MAI began in 1998 with the White House announcement of a series of initiatives targeting appropriated funds for HIV/AIDS prevention and treatment programs in minority communities. The Congressional Black Caucus worked with the Clinton Administration to formulate the approach. MAI activities are supported by the following agencies and offices in HHS: HRSA; CDC; National Institutes of Health; Substance Abuse and Mental Health Services Administration; Minority Communities Fund; Office of Minority Health; Office of Women’s Health. GAO was required by P.L. 109-415 to provide a report on a variety of issues related to MAI: U.S. Government Accountability Office, *Ryan White CARE Act: Implementation of the New Minority AIDS Initiative Provisions*, GAO-09-315, March 27, 2009, <http://www.gao.gov/new.items/d09315.pdf>.

⁶⁴ Previously under P.L. 109-415 a competitive grant system was used to award Part A and Part B MAI grants.

ACA and the Ryan White Program

As mentioned previously, ACA (P.L. 111-148, as amended) contains general provisions to increase access to health insurance for the U.S. population as well as coverage for people living with HIV/AIDS. Obtaining private health insurance has been difficult for individuals with HIV/AIDS and others living with serious preexisting medical conditions. A 2011 Institute of Medicine (IOM) report estimated that in urban areas, only about 13% of HIV patients in 2010 had private health insurance; most HIV patients were covered by Medicaid (36%), Medicare (12%), or a combination of these two programs (6%).⁶⁵ The remaining individuals were either uninsured and obtained their coverage through the Ryan White program (24%), or their insurance coverage information was missing or unknown (8%).⁶⁶

Pre-Existing Condition Insurance Plan (PCIP)

Prior to implementation of ACA in 2014, some individuals with HIV may obtain health insurance coverage under the Pre-Existing Condition Insurance Plan or PCIP.⁶⁷ This is a temporary (July 1, 2010, through December 31, 2013) state or federally administered program that serves as a “bridge for people with pre-existing conditions who cannot obtain health insurance coverage in today’s private insurance market;” as of July 31, 2012, a total of 82,000 people (not just HIV patients) had enrolled in a PCIP program.⁶⁸ In some cases, coordination between the state’s PCIP and ADAP has allowed the use of ADAP funds to purchase health insurance, covering HIV medications at lower cost and providing comprehensive health care. Although some ADAPs have reported barriers in coordination with PCIPs, as of December 2011, 24 ADAPs had enrolled 2,393 clients in PCIPs.⁶⁹

Medicaid Expansion

On January 1, 2014, ACA will allow for Medicaid coverage of a new eligibility group: individuals under the age of 65 with income up to 133% of the federal poverty level (FPL).⁷⁰ This

⁶⁵ According to the IOM report, “there are no recent national estimates of health coverage of individuals with HIV. The HIV Cost and Service Utilization Study (HCSUS), for example, the only nationally representative study of people with HIV/AIDS in care, was conducted from 1994 to 2000. A recent analysis of data from a convenience sample involving 12 medical sites located in urban cities throughout the United States showed that the majority of patients were covered under Medicaid (42%, including those dually eligible for Medicare) and the Ryan White program (24%). These data likely do not represent the national picture of health coverage of individuals with HIV, however, such as those in non-urban areas.” IOM (Institute of Medicine). 2011. *HIV Screening and Access to Care: Exploring the Impact of Policies on Access to and Provision of HIV Care*. Washington, DC: The National Academies Press, pp. 7-8.

⁶⁶ Ibid.

⁶⁷ Section 1101 of ACA.

⁶⁸ Department of Health and Human Services, “State by State Enrollment in the Pre-Existing Condition Insurance Plan, as of July 31, 2012,” press release, September 14, 2012, <http://www.healthcare.gov/news/factsheets/2012/09/pcip09142012a.html>.

⁶⁹ National Alliance of State and Territorial AIDS Directors, *ADAP Coordination with Pre-Existing Condition Insurance Plans (PCIPs), December 2011*, http://www.nastad.org/Docs/103359_ADAP%20and%20PCIPs%20-%20December%202011.pdf.

⁷⁰ Section 2001(a) of ACA. ACA establishes 133% of federal poverty level (FPL) based on modified adjusted gross income (MAGI) as the new mandatory minimum Medicaid income eligibility level. The law also specifies that an income disregard in the amount of 5% FPL will be deducted from an individual’s income when determining Medicaid eligibility based on MAGI, thus the effective upper income eligibility threshold for such individuals in this new eligibility group will be 138% FPL. On November 21, 2011, President Obama signed into law P.L. 112-56, which will

is a significant change from current Medicaid rules, which generally require individuals to have a low income and belong to a categorically eligible group: children, pregnant women, parents of dependent children, the elderly, or the disabled.⁷¹

Medicaid is a federal-state matching entitlement program; the federal portion currently varies from 50% in relatively affluent states to almost 80% in poorer states.⁷² For the new eligibility group, the federal government will pay 100% of the costs for 2014-2016; the federal share will gradually be reduced to 90% by 2020.

Some states have elected to cover the new eligibility group, or a portion of the new eligibility group, prior to January 2014 even though the enhanced match does not start until 2014; these states include California, Colorado, Connecticut, District of Columbia, Minnesota, New Jersey, and Washington State.⁷³ However, it is unclear how many states will decide to participate in the ACA Medicaid expansion due to a recent Supreme Court ruling. On June 28, 2012, in *National Federation of Independent Business v. Sebelius*, the Supreme Court held that the federal government cannot terminate current Medicaid federal matching funds if a state refuses to expand its Medicaid program to include the new eligibility group. Based on the Court's opinion, a state may refuse to participate in the expansion without losing any of its current federal Medicaid matching funds.⁷⁴

There could be a significant impact on Ryan White ADAP clients in those states that decide to cover the new Medicaid eligible group. According to a January 2012 report by NASTAD, 56% of ADAP clients served in June 2011 had incomes of 133% FPL or below (44% are less than or equal to 100% FPL, 12% are 101% to 133% FPL).⁷⁵ These individuals would be eligible to move to Medicaid coverage in 2014 if their states choose to participate in the expansion.

State Exchanges

By January 1, 2014, ACA requires that, in each state, an exchange must be established where individuals will be able to purchase private health insurance.⁷⁶ The exchange may be established

change the definition of income to include non-taxable Social Security in the definition of MAGI. For further information, see CRS Report R41997, *Definition of Income in ACA for Certain Medicaid Provisions and Premium Credits*, coordinated by Janemarie Mulvey.

⁷¹ Currently less than 1% of Medicaid enrollees have HIV. Disability is the most common eligibility pathway for people with HIV: three-quarters (74%) qualified for Medicaid as disabled, 17% are non-disabled adults, 5% are children and 3% are elderly. For all other Medicaid enrollees, 53% are children, 22% are disabled, 13% are non-disabled adults and 12% are elderly. Jen Kates, *Medicaid and HIV: A National Analysis*, The Henry J. Kaiser Family Foundation, Washington, DC, October 2011, pp. 5 and 8. CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by Alison Mitchell and Evelyne P. Baumrucker.

⁷² Under the current program, each state designs and administers its own Medicaid program within broad federal guidelines. This has resulted in wide variations among the states in coverage, benefits offered, and payment for services.

⁷³ CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz, p. 4.

⁷⁴ For a more detailed discussion, see the CRS Congressional Distribution Memo, *Selected Issues Related to the Effect of NFIB v. Sebelius on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act* by Kathleen S. Swendiman and Evelyne P. Baumrucker. Also, see <http://www.crs.gov/analysis/legalsidebar/pages/details.aspx?ProdId=117>, and <http://www.crs.gov/analysis/legalsidebar/pages/details.aspx?ProdId=121>.

⁷⁵ Murray C. Penner and Britten Pund, *National ADAP Monitoring Project Annual Report Module One*, National Alliance of State and Territorial AIDS Directors, Washington, DC, January 2012, Chart 20, p. 22.

⁷⁶ Section 1311 of ACA. For further information, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

by the state itself, in which case the state must declare its decision by November 16, 2012.⁷⁷ If the state decides not to set up the exchange, HHS will do so. Individuals with income between 100% and 400% FPL, who are not eligible for minimum essential coverage (other than through the individual health insurance market), may be determined to be eligible for financial assistance, in the form of premium tax credits, to purchase exchange coverage.⁷⁸ Up to 52% of Ryan White ADAP clients may be eligible for such assistance through the exchange.⁷⁹ States may also choose to implement a basic health program that provides health insurance for low-income individuals who are not eligible for Medicaid. Individuals who are eligible for enrollment in a basic health program have income between 133% FPL and 200% FPL.⁸⁰ Basic health programs could also benefit low-income individuals with HIV/AIDS.

Health insurance plans sold on the exchange must include diagnostic, preventive, and therapeutic services or products as essential health benefits (EHBs).⁸¹ The EHBs fall into 10 broad benefit categories.⁸² ACA does not list the EHBs, and to date HHS has not issued regulations.⁸³ HHS has instead released a bulletin which states that the EHBs “be defined by a benchmark plan selected by each State.”⁸⁴ The EHBs must also be included in Medicaid packages for newly eligible individuals starting in January 2014. These new Medicaid enrollees will receive either benchmark or benchmark-equivalent coverage. However, individuals with special medical needs and medically frail individuals are exempt from mandatory enrollment in such benchmark plans.⁸⁵

⁷⁷ Although the deadline for the declaration is November 16, 2012, in a letter to state Governors dated November 9, 2012, HHS extended the deadline for state-based exchange blueprint application submissions to December 14, 2012. <http://www.modernhealthcare.com/assets/pdf/CH83821119.PDF>

⁷⁸ The definition of minimum essential coverage includes government sponsored plans, such as, Medicare Part A, Medicaid, the Children’s Health Insurance Program, and employer-sponsored health plans. For further details, see CRS Report R41331, *Individual Mandate and Related Information Requirements under ACA*, by Janemarie Mulvey and Hinda Chaikind.

⁷⁹ Of ADAP clients served in June 2011, 52% had incomes 101 to 400% FPL (12% are 101 to 133% FPL, 20% are 134 to 200% FPL, 14% are 201 to 300% FPL, and 6% are 301 to 400% FPL). Murray C. Penner and Britten Pund, *National ADAP Monitoring Project Annual Report Module One*, National Alliance of State and Territorial AIDS Directors, Washington, DC, January 2012, Chart 20, p. 22.

⁸⁰ CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

⁸¹ Section 2001(c) of ACA.

⁸² Section 1302(b) of ACA. The ten categories of essential health benefits are: (1) ambulatory services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance abuse services, (6) prescribed drugs, (7) rehabilitative and habilitative services and devices, (8) lab services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

⁸³ ACA required the Department of Labor (DOL) to determine the benefits covered under a typical employer plan by conducting a survey of employer-sponsored coverage and report the results to HHS. The DOL report was released on April 15, 2011, “Selected Medical Benefits: A report for the Department of Labor to the Department of Health and Human Services.” <http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf> In addition, HHS requested that IOM conduct a study on the determination of the EHBs. The IOM report, “Essential Health Benefits: Balancing Coverage and Cost,” released on October 7, 2011, does not recommend specific services and medical products for inclusion in the EHBs. <http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx>

⁸⁴ “Essential Health Benefits Bulletin,” Center for Consumer Information and Insurance Oversight, December 16, 2011, p.8, http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

⁸⁵ In general, benchmark and benchmark-equivalent coverage may be less generous than traditional Medicaid, but there are some requirements that might make it more generous than private insurance. For further information, see CRS Report R41210, *Medicaid and the State Children’s Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyn P. Baumrucker et al.

In a letter to HHS Secretary Sebelius dated October 2, 2012, 57 patient advocacy organizations (including several HIV/AIDS groups) expressed their commitment to implementation of ACA, but also voiced concern over “the manner in which the essential health benefits are defined.”⁸⁶ In particular, the groups are concerned that the HHS bulletin outlines coverage of prescription drugs “in such a manner that it would be completely unworkable for patients, particularly for those with serious chronic health conditions. Limiting medications to just one drug per class will not meet the needs of patients and certainly does not meet the non-discriminatory protections outlined in the law.”⁸⁷ The letter urges HHS to “require plans, for both the private insurance market and the expanded Medicaid population, to cover a full range of medications that will meet the needs of all patients.” The letter goes on to state that a “robust formulary is necessary because not all patients respond to medicines in the same way. Physicians may need to change medicines over the course of an illness, patients may need more than one medication from the same class at the same time, and patients taking multiple medicines need alternatives to avoid harmful interactions.”

Other ACA Provisions

Several other provisions in ACA are of potential benefit to individuals with HIV/AIDS. ACA prohibits the cancellation of coverage by an insurer due to a preexisting condition, eliminates lifetime caps on insurance benefits and annual limits on coverage, and phases out the Medicare Part D so-called doughnut hole for individuals who are Medicare eligible, including those with HIV/AIDS.

Because ACA expands insurance coverage to those previously uninsured, the law also includes provisions that support changes to physician training, compensation, and practice.⁸⁸ These changes are intended to increase the size of the medical workforce, alter its composition (more primary care providers or other specialties in shortage), and incentivize practice in rural or other underserved areas.

The ACA includes a number of sections that aim to incentivize changes to the delivery of health care services. Specifically, the ACA supports models of care that are patient-centered with an emphasis on improved care coordination; the integrated delivery of health care services; and an increased emphasis on primary and preventive care. For example, the law creates the option for states to establish “health homes” for individuals with chronic conditions, including behavioral health disorders, in the Medicaid program.⁸⁹

ACA also permanently authorized the federal health center program administered by HRSA and created the Community Health Center Fund, including \$9.5 billion to be appropriated for health center operation in FY2011 through FY2015. However, due to fiscal constraints, to date these additional funds have not been used to expand the health center program but instead have been used to make up for discretionary appropriation reductions to the health center program.⁹⁰

⁸⁶ Letter from AIDS Action Committee of Massachusetts, AIDS Foundation of Chicago, and The AIDS Institute, et al. to Kathleen Sebelius, Secretary of Health and Human Services, October 2, 2012, <http://www.theaidsinstitute.org/federal-policy/sign-letters/57-patient-advocate-groups-call-robust-prescription-drug-coverage-essent>.

⁸⁷ Ibid.

⁸⁸ CRS Report R42029, *Physician Supply and the Patient Protection and Affordable Care Act*, by Elayne J. Heisler and Amanda K. Sarata.

⁸⁹ Section 2703(a) of ACA defines “health home” as “a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.”

⁹⁰ CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

2012 IOM Reports

Following enactment of ACA in March 2010, the White House Office of National AIDS Policy (ONAP) released a National HIV/AIDS Strategy (NHAS) in July 2010.⁹¹ The NHAS has three primary goals: reduce HIV incidence; increase access to care for people living with HIV/AIDS; and reduce HIV-related health disparities. In order to monitor the impact of ACA on achieving these goals, in September 2010 ONAP requested that IOM conduct a study to identify critical data and data systems that would allow for an evaluation of HIV care.

In March 2012, IOM released a report that identified 14 core indicators of clinical HIV care, and mental health, substance abuse, and supportive services.⁹² A second report, released in October 2012, “addresses how to obtain national estimates that characterize the health care of people with HIV within the context of the ACA, both before 2014 and after 2014 when key provisions of the ACA will be implemented.”⁹³

Reauthorization of the Ryan White Program

P.L. 111-87 provided authority for Ryan White Parts A, B, C, D, and F through FY2013. In addition, Section 2(a) of P.L. 111-87 removed the sunset provision that had been included in the 2006 reauthorization (§703 of P.L. 109-415). If reauthorization of the Ryan White program does not occur before October 1, 2013, it may continue to operate under general authority (Title III) of the PHS Act.

The long-range impact of ACA on the Ryan White program—meaning the replacement of health and treatment services provided under Ryan White with access to such services through health coverage via ACA—remains to be determined. If ACA remains intact moving forward, some states may decide not to participate in the Medicaid expansion. In those states, the need for the full range of services under Ryan White would remain. However, even if all states decide to cover the new Medicaid eligible group provided under ACA, there will be gaps that the Ryan White program could continue to fill, such as coverage of those individuals with HIV/AIDS who are undocumented immigrants or legal immigrants within the five-year Medicaid ban.⁹⁴ In addition, Ryan White provides dental care and support services, such as transportation, that may not be provided under Medicaid or private health insurance.

Following full implementation of ACA, there are concerns about whether there will be enough physicians to care for individuals who were previously uninsured.⁹⁵ There may also be shortages in particular geographical areas or certain specialists, such as primary care or those who are

⁹¹ The National HIV/AIDS Strategy is at <http://aids.gov/federal-resources/national-hiv-aids-strategy/nhas.pdf> For further information on NHAS, see <http://aids.gov/federal-resources/national-hiv-aids-strategy/overview/>

⁹² Institute of Medicine (IOM), *Monitoring HIV Care in the United States: Indicators and Data Systems*, Washington, DC, March 15, 2012, <http://www.iom.edu/Reports/2012/Monitoring-HIV-Care-in-the-United-States.aspx>.

⁹³ Institute of Medicine (IOM), *Monitoring HIV Care in the United States: A Strategy for Generating National Estimates of HIV Care and Coverage*, Washington, DC, October 5, 2012, <http://www.iom.edu/Reports/2012/Monitoring-HIV-Care-in-the-United-States-A-Strategy-for-Generating-National-Estimates-of-HIV-Care-and-Coverage.aspx>.

⁹⁴ For further information about the five year ban, see Office of the Assistant Secretary for Planning and Evaluation, *ASPE Issue Brief: Overview of Immigrants' Eligibility for SNAP, TANF, Medicaid, and CHIP*, March 2012, <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Eligibility/ib.shtml>.

⁹⁵ CRS Report R42029, *Physician Supply and the Patient Protection and Affordable Care Act*, by Elayne J. Heisler and Amanda K. Sarata.

knowledgeable about HIV/AIDS. During the month of July 2012, HRSA conducted a series of four listening sessions to allow stakeholders, including Ryan White grantees, advocacy organizations, state and local administrators, and others to provide comments on all aspects of the Ryan White program in preparation for reauthorization.⁹⁶

Appropriations

FY2012

For FY2012, the Obama Administration requested a total of \$2.376 billion for the Ryan White program, an increase of \$88 million compared with FY2010; most of the increase (\$82 million) would go to ADAP. The increase in ADAP funding would provide HIV medications for an estimated 13,000 additional patients. HRSA would use \$60 million for a new supplemental grant program for state ADAP programs with waiting lists or other cost containment measures. In a speech on December 1, 2011, World AIDS Day, President Obama indicated that that his Administration would commit an additional \$35 million for ADAP and an additional \$15 million for the Ryan White program.⁹⁷

The Senate Appropriations Committee reported S. 1599, the FY2012 Labor/HHS/Education bill, on September 22, 2011 (S.Rept. 112-84). The Senate bill would provide \$2.327 billion to HRSA for the Ryan White program. The House Appropriations Committee did not report a Labor/HHS bill for FY2012, but the chairman of the subcommittee introduced H.R. 3070 on September 29, 2011, accompanied by a detailed funding table; the amount for the Ryan White program was \$2.312 billion.⁹⁸

Congress provided temporary funding for Ryan White under several continuing resolutions while it completed final action on FY2012 appropriations: P.L. 112-33 provided funding through October 4, 2011; P.L. 112-36 provided funding through November 18, 2011; P.L. 112-55 provided funding through December 16, 2011; H.J.Res. 94 provided funding through December 17, 2011; and H.J.Res. 95 provided funding through December 23, 2011.

H.R. 2055, the Consolidated Appropriations Act, 2012, provided, in Division F, \$2.327 billion for the Ryan White program. However, Section 527 of Division F also contained an across-the-board rescission of 0.189%. The bill passed the House on December 16, the Senate on December 17, and was signed by the President on December 23, 2011.

FY2013

For FY2013, the Obama Administration requested a total of \$2.447 billion for the Ryan White program, an increase of \$79.594 million compared with FY2012; most of the increase (\$66.701 million) would go to ADAP. The FY2013 request would also provide an increase of \$20.478 million for Part C grants and a decrease of \$7.585 million for Part D grants.

⁹⁶ HRSA, Ryan White HIV/AIDS Program Reauthorization, Recorded Listening Sessions, available at <http://hab.hrsa.gov/reauthorization/index.html>.

⁹⁷ Remarks by the President on World AIDS Day at George Washington University, Washington, DC, <http://www.whitehouse.gov/photos-and-video/video/2011/12/01/president-obama-world-aids-day>.

⁹⁸ The detailed funding table was posted on the committee's website at http://appropriations.house.gov/UploadedFiles/FY12LH_Detail_SC_10_Rev_with_comparable.pdf. H.R. 3070 has not been considered by the subcommittee or the full committee and has not been reported.

The Senate Appropriations Committee reported S. 3295, the FY2013 Labor/HHS/Education bill, on June 14, 2012 (S.Rept. 112-176). The Senate bill would provide \$2.397 billion to HRSA for the Ryan White program. The House Appropriations Committee did not report a Labor/HHS bill for FY2013.

Congress provided temporary funding, through March 27, 2013, for the Ryan White program in P.L. 112-175, the Continuing Appropriations Resolution, 2013. Funding is at the FY2012 rate plus a very slight increase (less than 1%).

Under the Budget Control Act of 2011 (BCA, P.L. 112-25), a sequestration (automatic across-the-board spending cuts) is scheduled to occur on January 2, 2013, unless Congress enacts legislation modifying the BCA.⁹⁹ On September 14, 2013, the Office of Management and Budget (OMB) released a report providing preliminary estimates on the potential impact of the sequestration.¹⁰⁰ The OMB report indicates that HRSA discretionary programs, such as Ryan White, could receive an 8.2% cut due to the sequestration in FY2013.

⁹⁹ For further details about the BCA, see CRS Report R42050, *Budget “Sequestration” and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar, and CRS Report R42051, *Budget Control Act: Potential Impact of Sequestration on Health Reform Spending*, by C. Stephen Redhead.

¹⁰⁰ OMB Report Pursuant to the Sequestration Transparency Act of 2012 (P.L. 112-155), September 2012, available at http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/stareport.pdf.

Table I. Federal Funding for the Ryan White Program, FY1991-FY2013

(\$ in millions)

Fiscal Year	Part A	Part B	(ADAP) (non-add)	Part C	Part D	Part F AETC	Part F ADR	Total
FY1991	87.8	87.8	—	44.9	19.5	17.0	—	257.0
FY1992	120.5	106.6	—	48.7	19.3	16.9	—	312.0
FY1993	184.8	115.3	—	48.0	20.9	16.4	—	385.4
FY1994	325.5	183.9	—	48.0	22.0	16.4	7.0	602.8
FY1995	356.5	198.1	—	52.3	26.0	16.3	6.9	656.2
FY1996	391.7	260.8	(52)	56.9	29.0	12.0	6.9	757.4
FY1997	449.8	417.0	(167)	69.6	36.0	16.3	7.5	996.3
FY1998	464.7	542.8	(285.5)	76.2	40.8	17.2	7.8	1,150.2
FY1999	505.0	737.8	(461.0)	94.3	46.0	20.0	7.8	1,410.9
FY2000	546.3	823.8	(528.0)	138.4	51.0	26.6	8.0	1,594.2
FY2001	604.2	910.9	(589.0)	185.9	65.0	31.6	10.0	1,807.6
FY2002	619.4	977.2	(639.0)	193.8	71.0	35.3	13.5	1,910.2
FY2003	618.7	1,053.4	(714.3)	198.4	73.6	35.6	13.4	1,993.0
FY2004	615.0	1,085.9	(748.9)	197.2	73.1	35.3	13.3	2,019.9
FY2005	610.1	1,121.8	(787.5)	195.6	72.5	35.1	13.2	2,048.3
FY2006	603.6	1,119.7	(789.0)	193.5	71.7	34.6	13.1	2,036.3
FY2007	604.0	1,195.5	(789.5)	193.7	71.8	34.7	13.1	2,112.8
FY2008	627.1	1,195.2	(794.4)	198.8	73.7	34.1	12.9	2,141.8
FY2009	663.1	1,223.8	(815.0)	201.9	76.8	34.4	13.4	2,213.4
FY2010	678.1	1,276.8	(860.0)	206.4	77.6	34.7	13.6	2,290.2
FY2011	672.5	1,308.1	(885.0)	205.6	77.3	34.6	13.5	2,311.7
FY2012	671.3	1,355.6	(933.3)	215.1	77.2	34.5	13.5	2,367.2
FY2013 Request	671.3	1,422.3	(1,000.0)	235.6	69.6	34.5	13.5	2,446.8
FY2013 Senate	666.1	1,390.8	(963.3)	215.1	77.2	34.5	13.5	2,397.2

Sources: Amounts for FY2011 through FY2013 Request are found in HRSA, *FY2013 Justification of Estimates for Appropriations Committees*, p. 238-271, <http://www.hrsa.gov/about/budget/budgetjustification2013.pdf>. Amounts for FY2013 Senate are found in S.Rept. 112-176, p. 250-251. All other amounts are obtained from prior HRSA Justification documents.

Notes: Totals for FY1997 through FY2013 do not include \$25 million for SPNS provided via the PHS program evaluation tap (§241 of the PHS Act). Totals may not add due to rounding.

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